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VAGINAL CŒLIOTOMY

WITH REMARKS ON THE NEW FIELD IT OPENS UP FOR THE TREATMENT OF BACKWARD DISPLACEMENTS OF THE UTERUS WITH DISEASED ANNEXA BY VAGINO-FIXATION

BY

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VAGINAL CŒLIOTOMY.

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TREATMENT OF BACKWARD DISPLACEMENTS OF THE UTERUS WITH DISEASED ANNEXA BY VAGINO-FIXATION.

In a recent paper[1] on the indications of vagino-fixation, I stated that when one or both annexa were diseased, calling for removal, cœliotomy and ventro-fixation, rather than vagino-fixation, would be indicated. Some recent experiences have shown me that I drew the lines of indication entirely too narrow, and that the field of the operation may include the majority of backward displacements with adhesions and diseased annexa. The operation, therefore, is likely not only to supplant Alexander's operation, but to take the place of abdominal cœliotomy and ventro-fixation in a great number of cases. When I first began doing vagino-fixation, over fifteen months ago, I was struck with the ease with which I could, in the majority of cases, deliver the fundus of the uterus through the vaginal wound. I was thus enabled to pass the uterine sutures with the aid of sight, and to pass them as near the fundus as I desired. Judging from the description of the operation by Mackenrodt, Dührssen, and Winter, this was not an unimportant modification. These operators did not bring the fundus out through the vaginal wound, but passed the uterine sutures with the uterus in the vesico-uterine space, and consequently were compelled to rely chiefly on the sense of touch. While performing the operation it frequently occurred to me that I could easily tear through the fold of peritoneum between the bladder and uterus (as I had

[1] New York Medical Journal, October 27th, 1894.

frequently done without intention), and draw one or both annexa out through the vaginal wound if I so wished. But, as I had operated only in cases in which the annexa were apparently healthy or slightly diseased, I did not care to submit my patients to any extra risk by attempting an unnecessary manipulation within the peritoneal cavity. However, since the agitation of the past few months in favor of selecting the vaginal rather than the abdominal route for work in the lower part of the peritoneal cavity, I determined to put to the test the feasibility of carrying out the idea I had long entertained. An opportunity presented itself to me on November 25th. I was doing a vagino-fixation for complete retroflexion.

The patient, twenty-eight years of age, was married nine years, had a child a year later, and a miscarriage at three months, five years ago. Since the miscarriage she has had backache, pain in both groins extending down the thighs, painful menstruation, and a number of other complaints referable to her pelvic lesions. The uterus was in complete retroflexion, both annexa prolapsed, and I was not certain but that I made out some thickening of the distal end of the left tube. After bringing the uterus, or rather the fundus, out at the vaginal wound, I passed a temporary suture through it and gave it to my assistant, asking him to make gentle but steady traction toward the right side. With the index and middle fingers of my left hand I readily delivered the left tube and ovary through the wound. I inspected them carefully, and, finding them to be apparently healthy, returned both within the peritoneal cavity. The assistant was then asked to draw the fundus over to the left side, and with the index and middle fingers of my right hand I caught hold of the right annexa, but did not deliver them, which I could easily have done, as they presented nothing abnormal to the touch, and as the room in which I was operating (a tenement house) was growing very cold. At no time did any bowels come into view, nor did any come into contact with the operator's hands. Vagino-fixation was then done in the usual way, and a Tait's operation for laceration of the perineum. The whole series of operations—1, curettage, 2, inspection and exploration of the annexa, 3, vagino-fixation, 4, Tait's perineum—did not consume more than an hour. The time is mentioned only to show how expeditious the method is, and not as an important consideration. The patient has had absolutely no reaction. Pulse 84,

and temperature not going above 99° F. The only complaint made was slight pain in the perineum, from the stitches, for the first few days.

The second case in which I did a vaginal cœliotomy was on November 28th, on an inmate in the Montefiore Home for Chronic Invalids. It was for a complete retroversion and a subperitoneal fibroid, the size of a seckel pear, attached to the anterior aspect of the fundus. The patient had entered the Home eighteen months previous for a gastric ulcer, from which she recovered in a short time under proper diet and treatment. But she remained in the Home owing to her inability to work on account of backache, profuse and painful menstruation, and "falling of the womb" (a large rectocele, the size of a turkey's egg). The usual longitudinal incision in the anterior vaginal wall for vagino-fixation was made, the vaginal flaps dissected from the bladder, then the bladder was dissected from the uterus, and the vesico-uterine fold of peritoneum cut with scissors. The uterus was next drawn downward and forward by climbing up its anterior wall with three successive provisional sutures. The small fibroid then began to come into view, and was easily seized by a volsellum, and, taking hold of it with another volsellum, it was readily delivered through the vaginal incision. The capsule was incised and the tumor enucleated from its bed in the fundus, the resulting defect in the uterine wall being whipped over by a continuous catgut suture. The uterus was then vagino-fixated by three silk sutures and the vaginal wound closed in the usual way. The rectocele was next disposed of by an Emmet on the posterior vaginal wall. No reaction whatever as a result of the operation. Temperature only once reached 100° F.; pulse never above 84.

The third case was done at the Post-Graduate Hospital, on December 8th. The patient came from Meriden, Conn., and was referred to me by a former patient. She came to this country from Russia eighteen months ago, her husband having preceded her by three years. Married nine years, three children, last child five years ago. Well until coming to this country, shortly after which began to suffer with metrorrhagia, painful and frequent micturition, backache, pain in the left groin, and pain in various parts of the body. In spite of constant treatment she has been steadily growing worse. Two

months ago curetted by the local physician; much worse since then.

On examination she presented the following local conditions: A fairly-sized rectocele and cystocele, an extensive bilateral laceration of the cervix, with considerable hypertrophy of both lips. The body of the uterus was forward, slightly enlarged, and quite sensitive. The left tube at its distal end was the thickness of a lead-pencil, and was adherent to the side of the pelvis. Left ovary small but very sensitive. Right annexa apparently normal. On being told to press down, the rectum became prolapsed for the distance of two inches and presented numerous hæmorrhoidal elevations. Examination of the bladder by Kelly's method showed the interior of the organ to be studded with patches of hyperæmia, and erosions most pronounced at the sphincter vesicæ. Thorough curettage, removing considerable granulation tissue. The usual anterior longitudinal incision. Dissection of vaginal flaps from bladder, separation of bladder from uterus. Vesico-uterine fold of perineum torn through with index finger, fundus brought to the vaginal wound by provisional climbing sutures. With index and middle fingers of left hand broke up adhesions holding down tube. Delivered tube through vaginal incision. The fimbriæ distinct and ostium patent. Distal end thickened and congested. Then delivered left ovary in the same manner. It was rather small and showed several small cysts on its surface. These were incised with the scalpel, and a clear, yellowish fluid escaped. Both tube and ovary then returned within the peritoneal cavity. Right annexa palpated with index and middle fingers of right hand. Nothing abnormal detected, and they were not drawn out. After resecting a strip from either vaginal flap, thus doing an anterior colporrhaphy, vaginal wound sutured in the usual way. Amputation of the cervix. Colpoperineorrhaphy. Forcible dilatation of rectal sphincter and removal of hæmorrhoids by clamp and cautery. Duration, ninety minutes. Patient next day very comfortable; no reaction. Temperature, 99° F.; pulse, 78. This patient, as well as the other two, has rapidly convalesced from the operations, without one untoward symptom, and could have been up and about in a week, as far as the operation within the peritoneal cavity was concerned.

Quite lately a paper by Dührssen came into my hands, in

which he reports a number of cases in which he followed somewhat the same method. He terms it "vaginal cœliotomy," an appropriate term to my mind, and I have adopted it. Dührssen makes a transverse incision in the anterior vaginal fornix and delivers the fundus and annexa through it. I deem the transverse incision, however, less advantageous than the longitudinal. It does not afford so much space, and it does not allow of fixating the uterus in as favorable a position. In a few cases Dührssen experienced very great difficulty in returning the fundus into the peritoneal cavity. This difficulty does not occur with the longitudinal incision. It offers a further advantage in the feasibility of making a more extensive separation of the bladder from the uterus and broad ligaments.[1] In doing a vagino-fixation on the cadaver some time ago, and then opening the abdomen, I found that the bladder was completely separated from the uterus and broad ligaments, and was overlying the fundus of the uterus. This free separation of the bladder carries the ureters well forward and removes any risk of including them in any ligature that may be tied.

In my opinion the anterior longitudinal incision possesses many advantages over the transverse incision in the posterior vault for salpingo-oöphorectomy: 1, there is less hemorrhage, and such as occurs is under better control; 2, it affords more room; 3, there is no danger of cutting into the rectum; 4, there is less likelihood of coming into contact with the intestines in doing the necessary manipulations.

To me there seems to be almost no limit to the amount of work that can be done through the anterior longitudinal incision. If necessary in order to gain more room, the vaginal flaps can also be incised transversely, and the whole hand could readily be introduced into the abdominal cavity. It has also occurred to me how easy it would be to do a hysterectomy in this manner.

In the three cases above narrated it would have been exceedingly easy to ligate the ovarian arteries from above, and the remainder of the operation would have been less than easy. In following the enucleation method, it seems to me, it would also be much simpler and easier to do so from the fundus downward with every tissue in sight, than cutting from below upward in the

[1] Dührssen recently reported (Klin. Vort., September, 1894) a case in which, with the tranverse incision, he accidentally divided the right ureter. Such an accident could not occur with the longitudinal incision.

dark, and not being able to tell when you are cutting into the uterine tissue or keeping outside of it in the so-called vascular sheath. The next opportunity that I have, I intend doing a vaginal hysterectomy by this method.

The importance of being able to substitute vaginal for abdominal cœliotomy cannot be overestimated. I say this in spite of the fact that I have been exceedingly fortunate in my recent abdominal work. During this year (1894) I have performed 26 abdominal cœliotomies consecutively without a death. These were done for various conditions—large ovarian cancer, 1; ovarian cysts, 3; hysterectomies for fibroid tumors, 2; double pyosalpinx with extensive adhesions, 5; tubo-ovarian abscess, 4; ovarian abscess, 2; salpingo-oöphoritis with adherent retro verted uterus, 5; pyosalpinx unilateralis, 3; appendicitis, 1. They were performed under varying surroundings—Post-Graduate Hospital, St. Elizabeth's Hospital, and Montefiore Home for Chronic Invalids. In many of them the abdominal wound healed by primary union, in others again convalescence was retarded by stitch and mural abscesses of more or less severity. With some exceptions, the patients for the first few days underwent considerable misery from vomiting, thirst, and flatulence. In none has a ventral hernia followed thus far. In two, after a completely smooth convalescence and primary union, small superficial fistulæ, difficult to heal, developed some months afterward, though I used nothing but catgut within the abdomen, and only once a non-absorbable buried suture. I have made it a point to follow up my cases, and I see many a post-operative case in an extensive dispensary practice (embracing over sixteen hundred new cases in a year) that are lost sight of by the operators themselves. I am safe, therefore, in saying that my results, immediate and remote, will compare favorably with those obtained by the best operators. None of what is gone before is said to disparage abdominal work. Many of the cases operated on could not have been operated on except by the abdominal route, and were saved either from a fatal disease or one which was rendering life miserable or forming a burden to the victim and her surroundings. The disadvantages mentioned were a mere bagatelle compared with the great gains in life-saving and health that were achieved. Nevertheless, if these disadvantages can be avoided we owe it to the humane office of our calling and to our patients to strain every nerve to accomplish that deside-

ratum. I may frankly say that the vaginal route does not make it any easier for the operator. On the contrary, it is a method which makes it harder for the operator, but much easier for the patient.

One has only to compare a few cases treated by the abdominal and vaginal routes, respectively, to be convinced of the truth of this assertion. The advantages of the vaginal route may be stated briefly to be the following:

1. It opens up a smaller avenue for the introduction of deleterious germs. None but the operator's hand need come into contact with the peritoneum and intestines.

2. There is less manipulating of the intestines. In some instances, as in my three cases, they do not come into view, nor in contact with the operator's hands and instruments.

3. The absence of those distressing symptoms, such as thirst, vomiting, flatulence, etc., during the first twenty-four, forty-eight, or seventy-two hours, which may follow the simplest and most skilfully performed abdominal cœliotomy.

4. The avoidance of stitch and mural abscesses.

5. The avoidance of the subsequent occurrence of ventral hernia and troublesome fistulæ.

6. The absence of an external and skin cicatrix. This is more than merely an æsthetic gain. I have seen more than a few patients during the year in whom the cicatrix, though primary union had taken place, gave trouble by being painful, and showing from time to time an angry, red, and swollen appearance.

This is one side of the picture. But the trite saying, "There is nothing perfect under the sun," applies also to the vaginal method. It has its disadvantages. These, however, may be summed up in the one proposition—the greater difficulty of doing the operation—which has already been touched upon. But this, no doubt, will in a great measure be overcome by larger experience and more perfect technique. The danger from meeting with hæmorrhage difficult to control is not, in my opinion, very great. This is a point, however, which further experiences will determine.

Another great gain of the vaginal method not yet touched upon is that it opens up a large field for conservative surgery upon the uterus and annexa. The cases of backward displacements, with more or less disease of the annexa, one meets with

in public and private practice, form a very large percentage of the cases one is called upon to treat.[1] A conscientious and conservative person hesitates, in many of these cases, to open the abdomen and do what is commonly known as conservative surgery. One weighs the complications which may follow in the trail of a wound through the abdominal parietes. He resorts to curettage, electricity, ichthyol tampons, hot douches, pessaries, etc. He tells his patient she must expect to suffer more or less pain and be content to submit to treatment for a lengthened period, unless she is willing to undergo an abdominal section, which naturally carries with it some dread to the lay mind. Now, if by a method which does not call for an external incision the backward displacements can be permanently cured, the annexa brought into view and treated upon conservative lines, and with no greater danger or risks, if aseptically done, than attach to a curettage, where is the person who will not urge or avail himself of that method?

The writer needs scarcely to add that he does not wish to be understood as advising vaginal cœliotomy or vagino-fixation in every case of retroversion of the uterus, and in every case of salpingo-oöphoritis. In many cases the palliative treatment above referred to will prove sufficient. But there will be a fair percentage of cases in which it will fail even after a faithful and intelligent trial. It is in these cases in which palliative treatment has failed that he would urge the method described in this paper. He would also urge it in most of the cases of pyosalpinx and ovarian abscess met with, which have hitherto been treated by abdominal cœliotomy. It would be well, however, until our experience increases and our technique improves, to have our patients and ourselves prepared for an abdominal cœliotomy in the event of our failing to remove the diseased annexa by the vaginal route. The attempt, in the event of failure, would not in the least add to the dangers of the abdominal cœliotomy. Still the writer believes the cases would be few in number in which an operator with any experience in working through the vaginal route would fail.

[1] Of 2,500 cases in my dispensary practice during the past eighteen months, there were 452 cases of retroversions and flexions, the majority of these being complicated with adhesions and disease of the annexa. When we deduct the cases of pregnancies, 295, and the cases which were negative, 210, as far as statistics are concerned, we have a percentage of 22.65 of the total number of cases with pelvic affections.

NOTE.—Since the foregoing was sent to press I have done vaginal cœliotomy on four further cases. In one case both annexa were removed, as they were hopelessly diseased, the patient leaving the hospital fourteen days afterward. In another case of retroversion with long-continued backache and pain in both groins, the annexa were drawn out through the vaginal incision for inspection. The tubes were found in a fairly good condition, but the ovaries presented a number of cysts, one of which was excised and the remainder punctured. Both annexa were then returned within the peritoneal cavity. Convalescence was perfectly afebrile and satisfactory.

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